HCA Health Benefit Exchange Technical Advisory
Policy Content Meeting Notes: Federal Basic Health Program
Monday, July 25, 2011
3:30-4:30pm
Conference Call: US/CAN Toll Free: 1-888-450-5996
Participant Pass Code: 716538

HCA Participant: Molly Voris, Health Insurance Exchange Program Manager

TAC Participants:
Lisa Brandenburg
Sean Corry
Jim DeVleming
Scott Douglas
Jim Grazko
Anne Howland
Norm Inaba
Representative from NW Insurance Agencies for Robert Lien
Karen Merrikin
Jim Pinkerton
Howard Springer
Rudy Vasquez

Absent TAC Members:
Don Conant
Robert Lien
Sheryl Lowe/Jim Roberts
Sue Sharpe

Background by Molly:
Laid out in the ACA was a series of subsidy levels. Anyone up to 133% FPL is covered by Medicaid. Between 133-400% FPL are federal tax credits premium subsidies as well as cost sharing subsidies available for individuals. Those are given directly through the Exchange in that they go from the U.S. Dept of Treasury to the plan that an individual is enrolled in. In a "federally funded basic health program" states are allowed to build their basic health plan (BHP) modeled after Washington State's plan. The BHP would create a program for individuals within 134-200% FPL and the state would receive 95% of the value of the subsidies from the federal government. That money would serve to provide the benefits and any operational costs of the BHP.

TAC member questions:

- *In Washington, the BHP only covers adults. Is this assumed to be for the future?*
  -Yes. Children will still remain in Medicaid or the Children's Health Insurance Plan (CHIP) because they are funded at a higher rate. Combining BHP and CHIP is not one of the options laid out here.

- *Would Option 2 require that the state get a waiver?*
  -Yes, because you'd be making changes to Medicaid.

Introduction of discussion by Molly:
We'll walk through the options in this brief and have time to ask and answer questions. The main objective is to get TAC members' feedback about whether we are we asking the right questions. Are we dealing with the right considerations?

Option 1: Medicaid 0-133% FPL, Standalone Federal Basic Health program 134-200% FPL (benefit design per ACA)

Option 2: Medicaid + Federal Basic Health program funding for a re-branded low-income program (same benefits and providers, different risk pools)

Option 3: Medicaid 0-133% FPL, Tax credits/reduced cost sharing in Exchange 134-400% FPL

TAC member questions:

- *In what sense would Option 2 include be re-branding? Would everyone have the same benefits in Medicaid and the BHP?*
  -Yes, this rebranded NEW program would include the same compensation, same provider networks and same benefits. The intent is that it is a low income program.
  We'll look at reimbursement rates within each policy option.

- *Would 0-400% FPL stay in the same bucket?*
  -0-200% FPL would be in the new program and 200-400% FPL would stay in the Exchange (and will be subsidized) regardless of if we have a BHP.

- *If the 0-200% FPL group stands out from the Exchange, then they won't be contributing any operational costs to it?*
  –Yes, but it is unclear whether the BHP is a different issue completely. It could be housed in the Exchange.

Consideration 1: Coordination with Medicaid and Exchange:
Molly summarized that this consideration includes how each option handles the transition between programs based on income changes (i.e., Medicaid, Basic Health, subsidized Exchange). For instance, if there are two programs (Medicaid and BHP), we have two transition periods.

TAC member questions:

- *How often are individuals dis-enrolled as a result of changes in income in the groups of 0-133, 133-200, 200-400?*
  –This is a good point but it is not the venue for answering that question. A reference for this research question is Health Affairs article in Feb 2011.

- *Is it important for families and women who get pregnant to have coverage under the same roof?*

- *What is the advantage of having a Federal BHP at all? (Reimbursements are lower, complexity is higher, and now you're inserting another program in the mix so there's different eligibility and need to track individuals).*
  -Need to answer that through a sequential series of questions:

    - *What is the added cost to the state in operating a Federal BHP vs. serving low income populations via the Exchange?*
    - *Is the 5% reduction in subsidy dollars offset by any genuine savings other than potentially lower reimbursement to providers?*
    - *Does the aggregation of the premium subsidy and cost-sharing dollars eliminate a major element of complexity inherent in the Exchange for this population?*
    - *Will the health plans be paid less?*
    - *What's the effect on provider reimbursement?*
    - *How do the subsidies and cost-sharing play out?*
    - *What is the literal cost and what is the return on investment on the BHP for coordinated benefits and coordinated networks?*
    - *How does Federal BPH align to the principles/goal of the Exchange? (Big picture question)*
    - *What are the preferences of the population served? What do they value? What options might serve them best?*

- *How is the access going to be for people in the income ranges? We have access issues for Medicaid enrollees based on provider fee schedule. With BHP, enrollees have better access. You may see that if you combine it all- you may have access issues. What is the impact from the patient perspective?*

- *What covered health benefits are necessary to achieve highest level of functioning health status for the beneficiaries? Our enrollees that are in the low income categories need more than the traditional health services (ie, interpretive and transportation services).*
  -This relates to the question of would benefits in the BHP be the same as Medicaid or the essential health benefits package that will in the Exchange.

- *If we did these things, what would the impact be? How would it affect continuity of care? And how do we address that?*

Consideration 2: Cost Comparison:
Molly summarized that this consideration includes the costs of each option to the state. Amy Lischko will be doing a thorough cost analysis.

TAC member questions:

- *Is the 5% reduction in federal dollars offset by any genuine savings if you undertake a BHP Option 1 or 2? What other kinds of savings could there be and are they real? Is there a value to the aggregation of dollars and what might that look like and what savings would it accrue within the various levels of the value chain?*

- *What would happen to our admin costs?*

- *What's the added cost to the state for doing this?*

- *If there are savings, what will happen to the savings? Could we spend those savings?*

- *Assuming that having more people covered reduced uncompensated care, would some of the loss in reimbursement be offset by the cost savings (especially for larger facilities)?*

- *What are the guiding principles for moving forward? Critical items that have been addressed include sustainability, access to care, etc.*

Consideration 3: Administration Issues
Molly summarized that this consideration includes administrative functions of the option that the state decides to create the federal Basic Health program.

TAC member questions:
- *What administrative functions for operating both programs would be possibly duplicated? Are there savings in that?*

Consideration 4: Private Insurance Market Issues:
Molly summarized that this consideration includes how each option affects the private insurance market.

TAC member questions:
- *What model will be used for contracting in these programs? Who will participate if the model is a rate-taker kind of model (like Healthy Options)? Will the health plans be paid substantially less? How will providers be reimbursed? Would that kind of program be sustainable given the large expansion population? What would be the cost shifting implications and what is the impact on the market?*

- *Is there really a determinant size to have a viable Exchange? To what extent is the pool size important for an actuarial perspective vs. for other reasons such as cost spreading for the cost of the Exchange? Where does the pool size matter and for what reason?*

- *What is appropriate cost sharing for the population (from an enrollee perspective)?*

Public comment:
None

Next steps: - Molly Voris
We will take this to our consultant, Amy Lischko, along with received public written comments. Public comments should be sent to nelly.gozdek@hca.wa.gov. More information can be found at http://www.hca.wa.gov/hcr/exchange.html.

We'll send you the final version of the policy questions for the federal BHP options. Amy will draft a paper and then the TAC will talk again before a final paper is released. We will be dealing with issues simultaneously, so as the paper is being written we will use a similar format to

discuss other issues. We don't know when the next issue, criteria for qualified health plan, will come out- but we will give you a general idea by the end of the week or next week about the schedule for that.